		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155620	B. WING		08/04/2011
NAME OF P	ROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP CODE	
				FORD RD	
ZIONSVILLE MEADOWS			ZIONS	VILLE, IN46077	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUNCE CROSS-REFERENCED TO THE APP		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or the Investigation of	F0000		
		_	1,0000		
	Complaint IN00094022.				
	Complaint INOO	004022 substantiated			
	Complaint IN00094022 substantiated, Federal/State deficiencies related to the				
	_	ited at F223, F225, F226,			
	F272, F279 and	F314.			
	C 1-4 A	2 . 9 . 4 . 2011			
	Survey dates: August 3 & 4, 2011				
	F 117	000530			
	Facility number:				
	Provider number				
	AIM number: 1	00267290			
	Survey team:				
	Christi Davidsor				
	Courtney Hamil	ton RN			
	(08/04/2011)				
	Census bed type	<i>:</i>			
	SNF: 14				
	SNF/NF: 160				
	Total: 174				
	Census payor ty	pe:			
	Medicare: 22				
	Medicaid: 118				
	Other: 34				
	Total: 174				
	Sample: 3				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID:

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Facility ID:

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TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	OMPLETED		
		155620	B. WIN			08/04/2	08/04/2011	
		<u></u>	D. 1121		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	L		675 S F	ORD RD			
	LLE MEADOWS			L	/ILLE, IN46077			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION DATE	
IAG		es reflect state findings	+	IAG			DAIL	
		ace with 410 IAC 16.2.						
	cited in accordan	ice with 410 IAC 16.2.						
Quality review completed 8/9/11 Cathy Emswiller RN								
F0223	The resident has t	he right to be free from	1					
SS=E verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary								
	seclusion.							
The facility must not use verbal, mental, sexual, or physical abuse, corporal								
		oluntary seclusion.						
	Based on record	review and interview, the	F0	223	F 223 Abuse		08/12/2011	
	facility failed to	ensure residents were free						
	from sexual abus	se as evidenced by 3			This provider ensures that the residents have the right to be			
	employees failed	I to immediately report to			from verbal, sexual, physical			
	the administrator	or his/her designee if the			mental abuse, corporal			
	administrator wa	s not available in an			punishment, and involuntary			
	allegation of sex	ual abuse in a sample of			seclusion.			
	18 employees that	_			What corrective action(s) will	be		
	questionnaires fo	or the facility regarding			accomplished for those resid			
	reporting allegati	ions of abuse. (CNA #1,			found to have been affected	by		
	LPN #2, CNA #3				the deficient practice?			
	ŕ				Resident # B no longer resident	es at		
	Findings include	·			the facility.			
	C				•			
		esident #B was reviewed on			LPN # 2 no longer works at t	ne		
	08/03/11 at 2:00 p.n	n.			facility.			
	Diagnoses included	, but were not limited to,			CNA#1 and CNA#3 were			
		right side, stroke from a heart			provided re-education and			
		d dementia and hypertension.			disciplinary action related to			
					reporting allegations of abuse	€		
	A hospital social wo	ork flow sheet dated 07/22/11			and/or utilizing the All Staff			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	A. BUILDING 00		COMPLETED	
		155620	B. WING 08/04/20		011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
				1	ORD RD		
ZIONSVI	ILLE MEADOWS			ZIONSV	/ILLE, IN46077		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	\neg	ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	at 15:44 (3:44 n m), indicated, "Recd			Behavior Tracking Record.		
		as pt {patient} made allegation					
		sing} homenotified			How will you identify other		
		s about the allegations"			residents having the potentia	ıl to	
		s woodt the unegunonom			be affected by the same defi		
	A facility generated	questionnaire dated 07/23/11,			practice and what corrective		
		d any resident on Cottage 3			action will be taken?		
		n of abuse to you.{sic}"					
		"Roommatereported to CNA			All residents have the potent	ial to	
	1	nat man keeps asking me if my			be affected by the alleged		
	p is clean or fat."				deficient accident practice.		
	During an interview	with the Executive Director			Allegations of abuse and/or		
	(ED) on 08/03/11 at 5:10 p.m., the ED indicated she was not aware of this written statement from				neglect are reported to the		
					Executive Director, or design		
		ated the CNA did not report the			immediately. An investigation	n into	
		resident to a superior or			the allegation is initiated,		
	document the verbi	-			including resident assessme	nt,	
					updating the plan of care,		
	As of exit 08/04/11	no further			physician and family notificat	ION.	
		lence was provided to indicate			The resident(s) safety is maintained.		
	1	gation, staff or resident			mamamed.		
		al exam of the resident involved			What measures will be put	into	
		al abuse had occurred or			place or what systemic	iiito	
		mine if there were lasting			changes you will make to		
		cial harm to the resident either			ensure that the deficient		
		I the sexual verbiage from the			practice does not recur?		
	resident.	Ž.			practice does not recal!		
					Employees were re-educated	d on	
	2. A facility genera	ted questionnaire dated			abuse, including the types of		
		"2) Did any resident on			abuse, signs and/or symptor		
		y allegation of abuse to you.			abuse, reporting of abuse, a		
	{sic}" LPN #2 ii	ndicated,			interventions necessary to e		
		none call asking why mom was			resident safety. The inservice		
	upsetasked if her	mom had said anything about			completed through interactive		
	someone hurting he	r here at this facility." A note			participation by the Executive		
	to the side of the fo	rm indicated this was			Director or designee, by Aug		
	documented in the	nurse's notes.			12, 2011, and knowledge wa		
					validated through a post test	-	
	A nurse's note dated	1 06/26/11 at 7:30 p.m.					
					Employees were re-educated	d on	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE indicated, "...Daughter called stated family said the behavior management mother stated she had been raped and was really program, including the completion of the All Staff Behavior Tracking confused...." The nurse's note was entered by LPN Record, reporting of behaviors, and interventions necessary to ensure resident safety, by the During an interview with the ED on 08/03/11 at Memory Care Facilitator, by 5:10 p.m., the ED indicated she was not aware of August 12, 2011. Employee this nurse's note entry or the written statement. knowledge was validated through a post test. During an interview with the ED on 08/04/11 at 10:30 a.m., the ED indicated she did not have the Resident behaviors are monitored knowledge of the concern of Resident B's family utilizing the All Staff Behavior which was documented on 06/26/11 in the Tracking Record, which are Resident's nursing notes. reviewed by the Interdisciplinary Team each business day, as An employee communication form provided by the needed. The team reviews the ED on 08/04/11 at 10:30 a.m. indicated, "...nurse interventions to monitor the admitted to not reporting to supervisor {sign for effectiveness, and determines if at} time of phone call from dtr {daughter}...." new interventions are necessary. Nurse managers and department As of exit 08/04/11, no further heads report resident behavior to documentation/evidence was provided to indicate the Executive Director, or there was an investigation, staff or resident designee, on the weekends. The interviews, physical exam of the resident involved resident's comprehensive care to determine if sexual abuse had occurred or plan and resident care sheet are assessment to determine if there were lasting updated, as needed. mental or psychosocial harm to the resident on 06/26/11. Allegations of abuse and/or neglect are reported to the 3. A handwritten statement dated 07/28/11, Executive Director, or designee, upon occurrence. An indicated CNA #3 had been called a "rapist" by investigation into the allegation is Resident #B on 06/08/11. initiated, including resident assessment, staff or resident During an interview on 08/03/11 at 5:10 p.m., the interviews, psychosocial ED indicated CNA #3 did not report the incident monitoring, updating the plan of of Resident #B calling employee a "rapist" to care, and physician/family superior. notification. The resident(s) safety is maintained. As of exit 08/04/11, no further documentation/evidence was provided to indicate Noncompliance with reporting

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/04/2011
AND PLAN	OF CORRECTION PROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OR there was an investi interviews, physica to determine if sexu assessment to deterr mental or psychosor 06/08/11. A facility policy dat "Abuse Prohibition,	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) gation, staff or resident l exam of the resident involved al abuse had occurred or mine if there were lasting cial harm to the resident on ed February 2010, titled, Reporting, and Investigation,"	A. BUILDING B. WING STREET A 675 S F		COMPLETED 08/04/2011 (X5) COMPLETION DATE ions of ciplinary ng sible for npliance
	carereceive instruction orientation and periodinservice education. What constitutes absube, and whenR volunteer, or visitor witnesses abuse, or immediately notify which the resident resid	ployees whether direct tion/training on abuse during odically during ongoing The training will include: a. use b. to whom to report esident Abuse - Staff member, 1. Any individual who has a suspicion of , shall the charge nurse of the unit, esides" tes to complaint IN00094022.		The Executive Director i responsible with compliaresident allegations of all How will the corrective action(s) be monitored ensure the deficient provill not recur, i.e., what assurance program will into place? A CQI tool, (Resident and Questionaire) will be util weekly x 4, monthly x 2 quarterly x 3, to monitor compliance with abuse of The audits will be review CQI committee and action will be developed, as not improve compliance. Noncompliance with fact and procedure may resumployee education and disciplinary action up to including termination. Completion Date: 8/12/	to actice aquality I be put Id Staff and reporting. red by the on plans eded, to fility policy alt in filor and

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. E			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/04/2011	
	PROVIDER OR SUPPLIEF	<u> </u>	STREET . 675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN46077		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/04/20	ETED
NAME OF I	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE ORD RD		
ZIONSVI	LLE MEADOWS			ZIONSV	ILLE, IN46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PERCEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0225 SS=E	The facility must no have been found or mistreating resistance had a finding nurse aide registry mistreatment of resistance and finding nurse aide registry mistreatment of resistance and finding nurse aide registry mistreatment of resistance and finding has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including ir and misappropriate reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the results of all in reported to the addrepresentative and accordance with State survey and oworking days of the	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for a aide or other facility staff to de registry or licensing Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated it to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					
	facility failed to individuals who	review and interview, the ensure not to employ have been found guilty of of abuse or if a facility	F0	225	F 225 Abuse This provider ensures that employees to not use verbal, mental, sexual, or physical accorporal punishment, or		08/12/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE employee had a finding on the State nurse involuntary seclusion; (ii) the provider does not employ aide registry concerning abuse as individuals who have been—(A) evidenced by 3 employees failed to found guilty of abusing, immediately report to the administrator or neglecting, or mistreating residents by a court of law; or (B) his/her designee if the administrator was Had had a finding entered into the not available in an allegation of sexual State nurse aide registry abuse in a sample of 18 employees that concerning abuse, neglect, filled out questionnaires for the facility mistreatment of residents or regarding reporting allegations of abuse. misapporpriation of their property: and (iii) the provider reports any (CNA #1, LPN #2, CNA #3) knowledge it has of actions by a court of law against an employee. Findings include: which would indicate unfitness for service as a nurse aide or other 1. The record for Resident #B was reviewed on facility staff to the State nurse 08/03/11 at 2:00 p.m. aide registry or licensing authorities. Diagnoses included, but were not limited to, What corrective action(s) will be hemiparesis on the right side, stroke from a heart accomplished for those residents catheterization, mild dementia and hypertension. found to have been affected by the deficient practice? A hospital social work flow sheet dated 07/22/11 at 15:44 (3:44 p.m.), indicated, "...Recd Resident # B no longer resides at {received} referral as pt {patient} made allegation the facility. of "rape" at ns {nursing} home...notified Zionsville Meadows about the allegations...." LPN # 2 no longer works at the facility. A facility generated questionnaire dated 07/23/11, indicated, "...2) Did any resident on Cottage 3 CNA#1 and CNA#3 were report any allegation of abuse to you. {sic}...." provided re-education and CNA #1 indicated, "Roommate...reported to CNA disciplinary action related to x 2 (past month) 'That man keeps asking me if my reporting allegations of abuse p---- is clean or fat." and/or utilizing the All Staff Behavior Tracking Record. During an interview with the Executive Director (ED) on 08/03/11 at 5:10 p.m., the ED indicated How will you identify other she was not aware of this written statement from residents having the potential to CNA #1. ED indicated the CNA did not report the be affected by the same deficient language from the resident to a superior or practice and what corrective

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE action will be taken? document the verbiage. All residents have the potential to As of exit 08/04/11, no further be affected by the alleged documentation/evidence was provided to indicate deficient accident practice. there was an investigation, staff or resident interviews, physical exam of the resident involved Allegations of abuse and/or to determine if sexual abuse had occurred or neglect are reported to the assessment to determine if there were lasting Executive Director, or designee, mental or psychosocial harm to the resident either immediately. An investigation into time the CNA heard the sexual verbiage from the the allegation is initiated. resident. including resident assessment, updating the plan of care, 2. A facility generated questionnaire dated physician and family notification. 07/23/11, indicate, "...2) Did any resident on The resident(s) safety is Cottage 3 report any allegation of abuse to you. maintained. {sic}...." LPN #2 indicated, "Yes....daughter...phone call asking why mom was What measures will be put into upset...asked if her mom had said anything about place or what systemic someone hurting her here at this facility." A note changes you will make to to the side of the form indicated this was ensure that the deficient documented in the nurse's notes. practice does not recur? A nurse's note dated 06/26/11 at 7:30 p.m. Employees were re-educated on indicated, "...Daughter called stated family said abuse, including the types of mother stated she had been raped and was really abuse, signs and/or symptoms of confused...." The nurse's note was entered by LPN abuse, reporting of abuse, and interventions necessary to ensure resident safety. The inservice was During an interview with the ED on 08/03/11 at completed through interactive 5:10 p.m., the ED indicated she was not aware of participation by the Executive this nurse's note entry or the written statement. Director or designee, by August 12, 2011, and knowledge was During an interview with the ED on 08/04/11 at validated through a post test. 10:30 a.m., the ED indicated she did not have the knowledge of the concern of Resident B's family Employees were re-educated on which was documented on 06/26/11 in the the behavior management program, including the completion Resident's nursing notes. of the All Staff Behavior Tracking Record, reporting of behaviors, An employee communication form provided by the ED on 08/04/11 at 10:30 a.m. indicated, "...nurse and interventions necessary to ensure resident safety, by the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Memory Care Facilitator, by admitted to not reporting to supervisor {sign for August 12, 2011. Employee at} time of phone call from dtr {daughter}...." knowledge was validated through As of exit 08/04/11, no further a post test. documentation/evidence was provided to indicate The facility conducts pre-hire there was an investigation, staff or resident background/criminal history interviews, physical exam of the resident involved checks on all potential to determine if sexual abuse had occurred or employees. assessment to determine if there were lasting mental or psychosocial harm to the resident on The facility verifies the Certified 06/26/11. Nursing Aide certificates and nurse licensures prior to hire. 3. A handwritten statement dated 07/28/11, indicated CNA #3 had been called a "rapist" by Resident behaviors are monitored Resident #B on 06/08/11. utilizing the All Staff Behavior Tracking Record, which are During an interview on 08/03/11 at 5:10 p.m., the reviewed by the Interdisciplinary ED indicated CNA #3 did not report the incident Team each business day, as of Resident #B calling employee a "rapist" to needed. The team reviews the superior. interventions to monitor the effectiveness, and determines if As of exit 08/04/11, no further new interventions are necessary. documentation/evidence was provided to indicate Nurse managers and department there was an employee background check, heads report resident behavior to investigation, staff or resident interviews, physical the Executive Director, or exam of the resident involved to determine if designee, on the weekends. The sexual abuse had occurred or assessment to resident's comprehensive care determine if there were lasting mental or plan and resident care sheet are psychosocial harm to the resident on 06/08/11. updated, as needed. Allegations of abuse and/or A facility policy dated February 2010, titled, neglect are reported to the "Abuse Prohibition, Reporting, and Investigation," Executive Director, or designee, indicated, "...3. Employees whether direct upon occurrence. An care..receive instruction/training on abuse during investigation into the allegation is orientation and periodically during ongoing initiated, including resident inservice education. The training will include: a. assessment, staff or resident What constitutes abuse b. to whom to report interviews, psychosocial abuse, and when...Resident Abuse - Staff member, monitoring, updating the plan of volunteer, or visitor: 1. Any individual who care, and physician/family witnesses abuse, or has a suspicion of, shall notification. The resident(s)

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PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

1	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	A. BUILDING	00	COMP 08/04/2	LETED
AND PLAN	OF CORRECTION PROVIDER OR SUPPLIER LLE MEADOWS SUMMARY S (EACH DEFICIEN REGULATORY OR immediately notify which the resident r	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) the charge nurse of the unit,	A. BUILDING B. WING STR	DO D	E, ZIP CODE AN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY) ained. e with reporting for allegations of sult in disciplinary	LETED
				implementation with the facility management properties of the facility	Director is th compliance with tions of abuse. Forrective nonitored to ficient practice i.e., what quality ogram will be put esident and Staff will be utilized onthly x 2 and o monitor th abuse reporting. be reviewed by the e and action plans bed, as needed, to liance. e with facility policy may result in cation and/or tion up to and nation.	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/04/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0226 SS=E	written policies an mistreatment, neg and misappropriat Based on record facility failed to policy was follow	levelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. review and interview the ensure that the abuse wed by 3 employees that mmediately to the	F0226	F 226 Abuse This provider develops and implements policies and procedures that include the componentsof abuse: scree			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155620	B. WIN			08/04/201	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ORD RD		
ZIONSVI	LLE MEADOWS			1	VILLE, IN46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	administrator or his/her designee if the				training, prevention, identifica		
	administrator wa	s not available in an			investigationm, protection		
	allegation of sext	ual abuse in a sample of			andreporting/response.		
	18 employees tha	_			What corrective action(s) will	be	
		or the facility regarding			accomplished for those resid		
	•	ions of abuse. (CNA #1,			found to have been affected		
		*			the deficient practice?	, l	
	LPN #2, CNA #3	3)			•		
					Resident # B no longer resid	es at	
	Findings include:				the facility.		
						.	
	1. The record for Resident #B was reviewed on				LPN # 2 no longer works at t	he	
08/03/11 at 2:00 p.m.				facility.			
					CNA#1 and CNA#3 were		
	_	but were not limited to,			provided re-education and		
	_	ight side, stroke from a heart			disciplinary action related to		
	catheterization, mile	I dementia and hypertension.			reporting allegations of abuse	e	
	A.1 1/2 1 1.1	1.0. 11.07/20/11			and/or utilizing the All Staff		
	_	ork flow sheet dated 07/22/11			Behavior Tracking Record.		
	at 15:44 (3:44 p.m.)	as pt {patient} made allegation					
		rsing} homenotified			How will you identify other		
		s about the allegations"			residents having the potentia		
	Zionsvine wieddows	s doodt the difegutions			be affected by the same defi-	cient	
	A facility generated	questionnaire dated 07/23/11,			practice and what corrective		
		l any resident on Cottage 3			action will be taken?		
		of abuse to you. {sic}"			All residents have the potent	ial to	
		Roommatereported to CNA			be affected by the alleged		
	x 2 (past month) 'Th	at man keeps asking me if my			deficient accident practice.		
	p is clean or fat.	"			,		
					Allegations of abuse and/or		
	During an interview with the Executive Director				neglect are reported to the		
	(ED) on 08/03/11 at 5:10 p.m., the ED indicated				Executive Director, or design		
	she was not aware of this written statement from				immediately. An investigatio	n into	
		ted the CNA did not report the			the allegation is initiated,	_,	
		esident to a superior or			including resident assessme	nt,	
	document the verbia	ige.			updating the plan of care, physician and family notificat	ion	
	2 4 0 . 314	and a market and the discount of the discount			The resident(s) safety is		
		ted questionnaire dated			maintained.		
	0//23/11, indicate, "	2) Did any resident on			maintainea.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Cottage 3 report any allegation of abuse to you. {sic}...." LPN #2 indicated, What measures will be put into place or what systemic "Yes....daughter...phone call asking why mom was upset...asked if her mom had said anything about changes you will make to someone hurting her here at this facility." A note ensure that the deficient to the side of the form indicated this was practice does not recur? documented in the nurse's notes. Employees were re-educated on A nurse's note dated 06/26/11 at 7:30 p.m. abuse, including the types of abuse, signs and/or symptoms of indicated, "...Daughter called stated family said abuse, reporting of abuse, and mother stated she had been raped and was really interventions necessary to ensure confused...." The nurse's note was entered by LPN resident safety. The inservice was completed through interactive participation by the Executive During an interview with the ED on 08/03/11 at Director or designee, by August 5:10 p.m., the ED indicated she was not aware of 12, 2011, and knowledge was this nurse's note entry or the written statement. validated through a post test. During an interview with the ED on 08/04/11 at Employees were re-educated on 10:30 a.m., the ED indicated she did not have the the behavior management knowledge of the concern of Resident B's family program, including the completion which was documented on 06/26/11 in the of the All Staff Behavior Tracking Resident's nursing notes. Record, reporting of behaviors, and interventions necessary to An employee communication form provided by the ensure resident safety, by the ED on 08/04/11 at 10:30 a.m. indicated, "...nurse Memory Care Facilitator, by admitted to not reporting to supervisor {sign for August 12, 2011. Employee at} time of phone call from dtr {daughter}...." knowledge was validated through a post test. 3. A handwritten statement dated 07/28/11, indicated CNA #3 had been called a "rapist" by Resident #B on 06/08/11. Resident behaviors are monitored utilizing the All Staff Behavior During an interview on 08/03/11 at 5:10 p.m., the Tracking Record, which are ED indicated CNA #3 did not report the incident reviewed by the Interdisciplinary Team each business day, as of Resident #B calling employee a "rapist" to superior. needed. The team reviews the interventions to monitor the effectiveness, and determines if A facility policy dated February 2010, titled, "Abuse Prohibition, Reporting, and Investigation," new interventions are necessary. Nurse managers and department

Facility ID:

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
PROVIDER OR SUPPLIER	2	•	675 S F	.ddress, city, state, zip code ORD RD /ILLE, IN46077	•	
SUMMARY S (EACH DEFICIEN REGULATORY OR indicated, "3. Em carereceive instruct orientation and peri- inservice education. What constitutes ab abuse, and whenR volunteer, or visitor witnesses abuse, or immediately notify which the resident r	ETATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ployees whether direct etion/training on abuse during odically during ongoing The training will include: a. use b. to whom to report desident Abuse - Staff member, 1. Any individual who has a suspicion of , shall the charge nurse of the unit,		675 S F	ORD RD	The are t are t are in of ing s of ary	(X5) COMPLETION DATE
				How will the corrective action(s) be monitored to ensure the deficient practic will not recur, i.e., what quassurance program will be into place?	ce ality	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP - 08/04/2	LETED
	PROVIDER OR SUPPLIER		675 S F	ADDRESS, CITY, STATE, ZIP CO FORD RD VILLE, IN46077	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				A CQI tool, (Resident Questionaire) will be u weekly x 4, monthly x quarterly x 3, to monit compliance with abus. The audits will be revi CQI committee and awill be developed, as improve compliance. Noncompliance with fand procedure may reemployee education a disciplinary action up including termination. Completion Date: 8/	utilized 2 and 2 and for e reporting. fewed by the ction plans needed, to facility policy esult in and/or to and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CC A. BUILDING B. WING	00		ESURVEY PLETED 2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD					
ZIONSVI	LLE MEADOWS			VILLE, IN46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE : APPROPRIATE	(X5) COMPLETION DATE		

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES				(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155620	B. WIN	B. WING 08/04/2011			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
				1	ORD RD		
ZIONSVI	LLE MEADOWS			ZIONSV	ILLE, IN46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)		DATE
F0272	•	onduct initially and					
SS=D		prehensive, accurate, oducible assessment of					
	each resident's fur						
		ke a comprehensive					
		esident's needs, using the					
		ne State. The assessment					
	must include at lea	ast the following: demographic information;					
	Customary routine	•					
	Cognitive patterns						
	Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;						
	•	and health conditions;					
	Dental and nutritio						
	Skin conditions;						
	Activity pursuit;						
	Medications;						
	Special treatments Discharge potentia						
	• .	summary information					
	regarding the addi						
		the resident assessment					
	protocols; and						
		participation in assessment.					
		review and interview, the	F0	272	F272 Resident Assessment		08/12/2011
	facility failed to	ensure complete and			This provider completes a comprehensive assessment	of a	
	accurate assessm	ents were completed for			resident's needs, using the R		
	1 of 3 residents r	eviewed. (Resident #B)			specified by the State. Tkhe		
					assessment includes at least		
	Findings include	<u>.</u>			following: (i) Identification an		
	_				demographic information, (ii) Customary routine, (iii) cogn		
	The record for R	esident #B was reviewed			patterns, (iv) Communication		
	on 08/03/11 at 2:				Vision, (vi) Mood and behavior		
	511 00/03/11 at 2.	~ Р.ш.			patterns, (vii) Psyuchosocial		
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: 8	 35P511	Facility II	D: 000538 If continuation sh	neet Par	ge 18 of 32

85P511

Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPL	ETED
		155620	B. WIN			08/04/2	011
		II.	P. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER			1	ORD RD			
ZIONSVILLE MEADOWS			1	/ILLE, IN46077			
					1122, 1110077		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	, ,		DATE
					well-being, (viii) Physical		
	Diagnoses include	ded, but were not limited			functrioning and structural	۸.	
	to, hemiparesis	on the right side, stroke			problems, (ix) Continence, (x Disease dianosis and health		
		neterization, mild			conditions, (xi) Dental and		
	dementia and hy				nutritional status, (xii) Skin		
	demendia and my	pertension.			conditions, (xiv) Medications	, (xv)	
	There	Minimum Data C + OADC)			Special treatments and	, ,	
		Minimum Data Set (MDS)			procedures, (xvi) Discharge		
	Assessment date	ed 06/23/11 indicated, the			potential, (xvii) Documentatio		
	cognition of Res	ident #B was, missed the			summary information regard	ing	
	correct year by 2	2-5 years, missed current			the additional assessment		
	1	han a month or could not			performed through the reside		
	<u> </u>	wer and incorrect or no			assessment protocols, (xviii)		
	1 ^	y of the week. The MDS			Documentaiton of participation assessment. What corrective		
					action(s) will be accomplishe		
		vere no moods exhibited			those residents found to have		
	including, but no	ot limited to, depressed,			been affected by the deficien		
	feeling tired or to	rouble concentrating on		practice? Resident # B no longer			
	things. The MD	S indicated that neither			resides at the facility. How	will	
	hallucinations or	delusions were	you identify other residents				
	exhibited.			having the potential to be affected			
	Camonou.			by the same deficient practice			
	The MDC in dies	4.4 h.11			and what corrective action w		
		ited hallucinations were,			taken? Residents who exhil behavioral symptoms have the		
		periences in the absence			potential to be affected by the		
	of real external s	sensory stimuli" The			alleged deficient practice.		
	MDS indicated of	delusions were,			Resident's with behaviors we	ere	
	"misconception	ns or beliefs that are			reviewed by the Interdisciplir		
	firmly held, cont	trary to reality"			Team to ensure resident		
		<u>, </u>			diagnosis and behaviors are		
	Δ social service	note dated 06/03/11			assessed and behavior care		
					plans were developed and		
		s {resident} unable to			individualized to ensure behavioral problems and		
	1	she is tearful. States she			interventions were specific to	,	
	just 'feels so sad	.'Tearful"			meet the resident's needs.		
					measures will be put into p		
	An interdisciplin	nary progress note dated			or what systemic changes		
	1	p.m. indicated Resident			will make to ensure that the		
	1 50,05,11 41 2.00	r maioatoa reolidone					

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	i '	(X2) MULTIPLE CONSTRU A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR S		STREET ADDRES 675 S FORD ZIONSVILLE,		•
PREFIX (EACH I	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION LACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
#B's daug time that to psychiatrical Anurse's sindicated out of the "Res {resting the box or Anurse's sa.m., indicated transferred hospital. Resident # 06/07/11 sinpatient of Resident # 06/15/11 sa also stating her" Resident # evaluation "she may visual sting states this A physicia 06/17/11 is returned for the psychiatrical states of the psychiatrical states this	ter informed the facility at this ne resident had three previous	recent many the Bell assistant and	ficient practice does not cur? Employees were educated on the behavior anagement program, include completion of the All Stathavior Tracking Record, sessment of the resident haviors, reporting of behad interventions necessary sure resident safety, by the mory Care Facilitator, by gust 12, 2011. Employed owledge was validated the cost test. Licensed nurse are re-educated by the ecutive Director, or design August 12, 2011, on the sessment of residents with havioral issues and/or egations of abuse. Employees were re-educated thoost test. Social Service apployees were re-educated thoost test. Social Service apployees were re-educated thoost test. Social Service apployees were re-educated the cost test. Social Service apployees were re-educated to ensuring resident diagnoral problems and derventions necessary to expect the resident diagnoral problems and the resident diagnoral problems and the resident needs are a literal problems and the resident needs are a literal to develop an intering replan. The Resident Cate the is updated to reflect ecific resident needs. The resident needs are the resident needs. The resident needs are the resident needs.	ruding off with aviors, / to ne rough s nee, ch byee rough e d by ust sment ne ram vioral s sisis, ensure met. ents n re

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155620				08/04/2	011	
			B. WIN		DDDDGG GWYL GWLED GUD			
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
					FORD RD			
ZIONSV	ILLE MEADOWS			ZIONS\	VILLE, IN46077			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	 	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	{sic} 7) Insom	nia trazadone {sic}"			Interdisciplinary Team review	VS		
					residents with a change of			
	A social service	note dated 06/23/11			condition to ensure the resident			
		sident was interviewed for			needs are met. The resider			
					care plan and Resident Care			
	1	sment. The note indicated,			Sheet are updated, as need Resident behaviors are mor			
	`	t} stated she's acting in a			utilizing the All Staff Behavio			
	play which is w	hy she is here.			Tracking Record, which are	/I		
					reviewed by the Interdiscipli	narv		
	A recapitulation	dated 07/01/11 through			Team each business day, as	-		
	A recapitulation dated 07/01/11 through				needed. The team reviews			
	07/31/11, with an original physician's				interventions to monitor the			
	order dated 06/17/11, indicated,				effectiveness, and determine	es if		
	"Trazodone 50mg {milligram} tab				new interventions are neces	sary.		
	{tablet} take 1 tablet by mouth daily at				Nurse managers and depart			
	bedtime"				heads report significant resi	dent		
					behavior to the Executive			
		1 . 107/01/11 1			Director, or designee, on the	9		
	1 *	dated 07/01/11 through			weekends. The resident's			
	07/31/11, with a	n original physician's			comprehensive care plan ar			
	order dated 06/1	7/11, indicated,			resident care sheet are upda	ated,		
	"Citalopram 4	Omg tablet take 1 tablet by			as needed. Resident's with			
	1 ^	he morning (For:			behaviors were reviewed by			
	Celexa"	ne morning (1 or.			Interdisciplinary Team by Au	•		
	Celexa				12, 2001, to ensure resident diagnosis and assessments			
					incorporated into behavior c			
	During an interv	view on 08/04/11 at 10:30			plans to ensure behavioral	aic		
	a.m., the Execut	ive Director (ED)			problems and interventions	were		
	indicated the fac	cility was not aware of			specific to meet the resident			
		sychiatric history.			needs. Resident care plans			
	1 Resident #D s ps	sycination instory.			Resident Care Sheets were			
		1			updated, as needed. Socia	I		
	1	relates to complaint			Service is responsible for			
	IN00094022.				implementation and complia	nce		
					with the facility behavioral			
	3.1-31(c)(4)				management program and t			
					development of specific beh			
					care plans. MDS is respon			
					for compliance with resident			
					assessment and care plans.			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 08/04/2	LETED
	PROVIDER OR SUPPLIEI	R	675 S F	ADDRESS, CITY, STATE, ZIP CODE FORD RD VILLE, IN46077	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
				How will the corrective action(s) be monitored a ensure the deficient pra will not recur, i.e., what assurance program will into place? An CQI too (Assessment) will be utili weekly x 4, monthly x 2 a quarterly x 3, to monitor compliance with resident assessment. The audits reviewed by the CQI con and action plans will be developed, as needed, to compliance. Noncomplia facility policy and proced result in employee educa and/or disciplinary action and including termination Completion Date: 8/12/	ctice quality be put I zed and will be nmittee o improve ance with ure may ation up to	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CC A. BUILDING B. WING	00		ESURVEY PLETED 2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP C	CODE			
ZIONSVI	LLE MEADOWS		ZIONSVILLE, IN46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE : APPROPRIATE	(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155620	B. WING			08/04/20	011
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			675 S F	ORD RD		
	LLE MEADOWS			ZIONSV	/ILLE, IN46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	rE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC1)		DATE
F0279	A facility must use	the results of the velop, review and revise the					
SS=D		nensive plan of care.					
	l locidones compres	ionorro pian or care.					
	The facility must d	evelop a comprehensive					
	•	resident that includes					
		tives and timetables to meet					
		al, nursing, and mental and Is that are identified in the					
	comprehensive as						
The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that							
		•					
		e required under §483.25					
	•	ed due to the resident's					
		under §483.10, including the					
	-	tment under §483.10(b)(4).	E02	70		•	00/12/2011
		review and interview, the	F02	2/9	F 279 Care		08/12/2011
		ensure accurate and			Diam		
		ans were developed for			Plan		
		f 3 residents reviewed for			This provider develops and		
	behavior care pla	ans in a sample of 3. (#B)			completes care plans related comprehensive assessment		
					resident's needs, using the R		
	Findings include	:			specified by the State.	"	
	The record for R	esident #B was reviewed			What corrective action(s) will		
	on 08/03/11 at 2:	00 p.m.			accomplished for those resid		
					found to have been affected the deficient practice?	Dy	
	Diagnoses includ	led, but were not limited			and demonstrate produces.		
	to, hemiparesis	on the right side, stroke			Resident # B no longer resident	es at	
	from a heart cath	eterization, mild			the facility.		
	dementia and hyp	pertension.			11		
		-			How will you identify other residents having the potentia	uto	
	The admission M	Iinimum Data Set (MDS)			be affected by the same define		
		()			practice and what corrective		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE action will be taken? Assessment dated 06/23/11 indicated, the cognition of Resident #B was, missed the Residents who exhibit behavioral correct year by 2-5 years, missed current symptoms have the potential to month by more than a month or could not be affected by the alleged deficient practice. provide and answer and incorrect or no answer to the day of the week. The MDS Resident's with behaviors were indicated there were no moods exhibited reviewed by the Interdisciplinary including, but not limited to, depressed, Team to ensure behavior care feeling tired or trouble concentrating on plans were completed and individualized to ensure things. The MDS indicated that neither behavioral problems and hallucinations or delusions were interventions were specific to exhibited. The MDS indicated Resident meet the resident's needs. #B exhibited physical and verbal What measures will be put into behaviors which occurred 1 to 3 days. place or what systemic changes you will make to A nurse's note dated 06/02/11 at 10:55 p.m., ensure that the deficient indicated Resident #B was yelling at staff, getting practice does not recur? roommates clothes and putting them on the floor and spit out 5 p.m. medications. Employees were re-educated on the behavior management A nurse's note dated 06/03/11 at 3:00 p.m., program, including the completion indicated Resident #B stated, "I don't want to eat of the All Staff Behavior Tracking {sign for with} a bunch of old b-----!" Record, reporting of behaviors, and interventions necessary to A nurse's note dated 06/06/11 at 7:00 a.m. ensure resident safety, by the indicated Resident #B pulled the call light out of Memory Care Facilitator, by the wall. August 12, 2011. Employee knowledge was validated through A nurse's note dated 06/06/11 at 6:50 p.m. a post test. indicated Resident #B yelled out, "...I will kill you!"...." Social Service employees were re-educated by outside Hospital records indicated Resident #B was consultants by August 12, 2011, admitted for psychiatric treatment from 06/07/11 on the behavior management through 06/17/11. program and ensuring resident behavioral and psychosocial care A nurse's note dated 06/18/11 at 9:00 a.m., plans address the resident indicated Resident #B was found on the floor of diagnosis, behavioral problems

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the resident room at 5:30 a.m. naked. and interventions necessary to ensure specific resident needs are met. Employee knowledge A nurse's note dated 06/24/11 untimed, indicated, was validated through a post test. "Resident continue to seek exit all the time...." A nurse's note dated 07/13/11 indicated, "...I need MDS employees were to get the big yellow bus and go...." re-educated by outside consultants by August 12, 2011, A nurse's note dated 07/20/11 at 7:10 p.m. on the development of indicated Resident #B, "...had behaviors, would try comprehensive care plans to to jump out of w/c {wheelchair}, and said ensure accurate and complete someone tried to burn and {illegible}...." care plans are developed for residents to meet their A care plan dated 07/05/11 indicated Resident #B individualized needs. Employee was at risk for side effects related to psychotropic knowledge was validated through medications. Documentation lacked indications or a post test. interventions related to behaviors included, but not limited to, yelling, taking clothes off, exit seeking, or delusions. Resident behaviors are monitored utilizing the All Staff Behavior During the end of day conference on 08/03/11, Tracking Record, which are care plans for behaviors for Resident #B were reviewed by the Interdisciplinary requested from the Executive Director (ED). Team each business day, as needed. The team reviews the During an interview on 08/04/11 at 10:30 a.m., interventions to monitor the The ED indicated there were no care plans for effectiveness, and determines if behaviors on Resident #B. No further new interventions are necessary. documentation provided at this time. Nurse managers and department heads report resident behavior to During an interview in the exit conference on the Executive Director, or designee, on the weekends. The 08/04/11 at 5:00 p.m., care plans for behaviors for resident's comprehensive care Resident #B were requested. ED provided an plan and resident care sheet are interim care plan for Resident #B that was dated updated, as needed. 06/03/11 and indicated this care plan was all there was. The interim care plan lacked the Resident's with behaviors were development of behavior care plans. reviewed by the Interdisciplinary Team by August 12, 2001, to As of exit 08/04/11 no further ensure behavior care plans were documentation/evidence was provided to indicate completed and individualized to there were behavior care plans developed and ensure behavioral problems and

Facility ID:

OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	A. BUILDING	00	COMP 08/04/2	LETED
PROVIDER OR SUPPLIER		675	EET ADDRESS, CITY, STATE, ZIP O S S FORD RD NSVILLE, IN46077		
SUMMARY S (EACH DEFICIEN REGULATORY OR written timely.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) tes to complaint IN00094022.	675	PROVIDER'S PLAN OF COX PROVIDER'S PLAN OF COX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	pecific to needs. and Resident pdated, as sponsible for compliance avioral am. for illity care stive ored to at practice what quality in will be put an) will be monthly x 2 monitor navioral care fill be led, to improve mpliance with ocedure may education up to nation.	(X5) COMPLETION DATE

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00		e survey pleted /2011
	PROVIDER OR SUPPLIER		675 S F	ADDRESS, CITY, STATE, ZIP FORD RD	CODE	
	LLE MEADOWS		ZIONS	VILLE, IN46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155620 08/04/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must maintain clinical records on F0514 each resident in accordance with accepted SS=D professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. F0514 F 514 Medical Records Based on observation, record review and 08/12/2011 This provider maintains clinical interview the facility failed to document records on each resident in behaviors on behavior sheets for 2 of 3 accordance with accepted residents reviewed for behavior tracking. professional standards and are (i) complete; (ii) Accurately (#B, #D) documented; (iii) readily accessible; and (iv) Findings include: systemaltically organized. What corrective action(s) will be 1. The record for Resident #B was accomplished for those residents reviewed on 08/03/11 at 2:00 p.m. found to have been affected by the deficient practice? Diagnoses included, but were not limited to, hemiparesis on the right side, stroke Resident # B no longer resides at the facility. from a heart catheterization, mild dementia and hypertension. Resident # D: resident's plan of care was reviewed by the The admission Minimum Data Set (MDS) interdisciplinary team and the behavioral care plans and Assessment dated 06/23/11 indicated, the Resident Care Sheet were cognition of Resident #B was, missed the updated, as needed. correct year by 2-5 years, missed current month by more than a month or could not How will you identify other residents having the potential to provide and answer and incorrect or no be affected by the same deficient answer to the day of the week. The MDS practice and what corrective indicated there were no moods exhibited action will be taken?

Facility ID:

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIER/CLIA (X2) MULTIPLE CONSTRUCTIO			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155620	B. WIN			08/04/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				FORD RD		
ZIONGVI	LLE MEADOWS				VILLE, IN46077		
	LLE WIEADOWS			ZIONS	VILLE, 11146077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	including, but no	t limited to, depressed,					
	feeling tired or tr	ouble concentrating on			Residents who exhibit behav		
	things The MD	S indicated that neither			symptoms have the potentia	l to	
	hallucinations or				be affected by the alleged		
		MDS indicated Resident			deficient practice.		
					Resident's with behaviors w	ere	
	#B exhibited phy				reviewed by the Interdisciplin		
	behaviors which	occurred 1 to 3 days.			Team to ensure resident		
					diagnosis and behaviors are		
		06/02/11 at 10:55 p.m.,			assessed and behavior care		
		B was yelling at staff, getting			plans were developed and		
		and putting them on the floor			individualized to ensure		
and spit out 5 p.m. medications.				behavioral problems and			
		06/02/11 2.00			interventions were specific to	P	
	A nurse's note dated 06/03/11 at 3:00 p.m., indicated Resident #B stated, "I don't want to eat				meet the resident's needs.		
		-			What measures will be put	into	
	{sign for with} a bu	nen of old b!			place or what systemic		
	A nurse's note dated	06/06/11 at 7:00 a.m.			changes you will make to		
		B pulled the call light out of			ensure that the deficient		
	the wall.	puned the can right out of			practice does not recur?		
	the wan.				practice account recars		
	A nurse's note dated	06/06/11 at 6:50 p.m.			Employees were re-educate	d on	
		B yelled out, "I will kill			the behavior management		
	you!""				program, including the comp	letion	
					of the All Staff Behavior Trac	king	
	Hospital records ind	licated Resident #B was			Record, reporting of behavio	ors,	
	admitted for psychia	atric treatment from 06/07/11			and interventions necessary	l l	
	through 06/17/11.				ensure resident safety, by th	I	
					Memory Care Facilitator, by	I	
		06/18/11 at 9:00 a.m.,			August 12, 2011. Employee	I	
		B was found on the floor of			knowledge was validated thr a post test.	ougn	
	the resident room at	5:30 a.m. naked.			a post tost.		
		06/04/11			Social Service employees w	ere	
		06/24/11 untimed, indicated, to seek exit all the time"			re-educated by outside		
	Resident continue	to seek exit all the time"			consultants by August 12, 20	011,	
	A nursals note detad	07/13/11 indicated, "I need			on the behavior managemer		
	to get the big yellow	-			program and ensuring reside	I	
	to get the dig yellow	ous and go			behavioral and psychosocial	care	
					plans address the resident		

li ´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	BUILDING 00 COMPLI		ETED	
		155620	B. WIN			08/04/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹					
ZIONIOVIII I E ME A DOVAJO			1	ORD RD			
ZIONSVILLE MEADOWS			ZIONSV	/ILLE, IN46077			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Documentation lack	ked behavior sheets until			diagnosis, behavioral proble	ms	
	07/20/11. Resident	#B presented with behaviors			and interventions necessary	to	
	on admission on 06	/02/11, and behavior sheets			ensure specific resident nee	ds	
	should have been in	nitiated at that time.			are met. Employee knowled	ge	
					was validated through a pos	t test.	
	During an interview	on 08/04/11 at 3:30 p.m., the					
		itator indicated there were not			Resident behaviors are mon	itored	
	behavior sheets for				utilizing the All Staff Behavio	r	
					Tracking Record, which are		
	During the end of d	ay conference on 08/03/11 at			reviewed by the Interdiscipling	-	
	5:00 p.m., all Resident B's behavior sheets were				Team each business day, as		
requested from the Executive Director (ED).				needed. The team reviews t	:he		
()				interventions to monitor the			
	As of exit 08/04/11, no further documentation was				effectiveness, and determine		
	provided. The record lacked documentation of				new interventions are neces	-	
		for the time of Resident #B's			Nurse managers and depart		
	admission until 07/2				heads report resident behavi	or to	
					the Executive Director, or		
	2. The record for R	esident #D was reviewed			designee, on the weekends.		
	08/04/11 at 3:30 p.r				resident's comprehensive ca		
					plan and resident care sheet	are	
	Diagnoses included	, but were not limited to,			updated, as needed.		
		sions, hypertension and a			Noncompliance with reportin	a	
	history of seizure di				behaviors utilizing the All Sta		
					Behavior Tracking Record, n		
	A nurse's note on 0	7/07/11 at 2:30 p.m. indicated			result in disciplinary action, t		
		admitted from receiving			and including termination.		
	psychiatric treatmen	9					
		•			Social Service is responsible	for	
	A nurse's note dated	1 07/07/11 at 7:50 p.m.			implementation and complia		
		er nurse screamedasked what			with the facility behavioral		
	1	resident tried hit her she then			management program.		
		ent came out{sign for with}			· · · · ·		
		tated 'want to kill her.'"			How will the corrective		
					action(s) be monitored to		
	A nurse's note dated	1 07/15/11 at 2:30 p.m.			ensure the deficient practic	e	
	1	sident} displaying aggressive			will not recur, i.e., what qua	ality	
		staff. Attempting to hit			assurance program will be	put	
		{as needed} Zyprexa"			into place?		
		tion on 08/04/11 at 4:30 p.m.,					
					A CQI tool (Psychoactive		

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/04/2011
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP COI 675 S FORD RD ZIONSVILLE, IN46077	
ZIONSVILLE MEADOWS	ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) Medication/Behavior Management) will be used weekly x 4, monthly x 2 quarterly x 3, to monitor compliance with the best management program audits will be reviewed committee and action to be developed, as need improve compliance. Noncompliance with far and procedure may resemployee education and disciplinary action up to including termination. Completion Date: 8/1	tilized 2 and or chavior . The by the CQI clans will led, to cility policy sult in nd/or o and